responsible for this abscess. We had experience with this operation in the past, and our results were similar to those mentioned in the literature.

Our first publication related with the conservative approach for the management of this condition [11] was published in 2000. Yet, many publications related to the surgical treatment of this condition indicate that the majority of surgeons continue using an aggressive approach for the treatment of this self-limited condition. We learned that we surgeons, in general, do not like presentations and publications advocating non-operative treatments.

27.2 Part II: Perianal Fistula and Rectovestibular Fistula with Normal Anus in Females

Perianal fistula in baby girls is extremely rare. However, we decided to discuss this entity together with a condition that received different names, including:

- N type of fistula
- Double termination of the intestinal tract
- Perineal canal
- Congenital H-type vestibular fistula
- Rectovestibular fistula with normal anus

We were very surprised to find similarities between the condition that received five different names in the literature and the acquired perianal fistula.

We previously published our experience with the surgical treatment of the "H type of rectovestibular fistula" [37]. Like most authors [38–55], we thought that all cases suffering from this condition were congenital.

Subsequently, we had the opportunity to read some papers in which the authors believed that this was an acquired condition [56, 57]! One of these reports [57] presents an overwhelming experience in favor of the idea that this is an acquired condition. From a series of 182 cases, 85 % of the cases had a history of a local inflammation prior to the diagnosis of the fistula. Other surgeons, even when they think that this is a congenital malformation, reported some spontaneous closures of the fistula [58], or they mentioned the occurrence of local abscesses prior to the diagnosis [59]. Finally, some authors believe that some cases could be congenital and others could be acquired [60–62]. As a consequence of this controversy, we started looking at our cases with a different suspicion in mind. We recently had two little female infants suffering from a fistula between the vestibule of the genitalia and a crypt of the pectinate line of the anal canal. We suspected that these babies could be suffering from an acquired perianal fistula, like the one that we discussed in male infants. Consistent with our conservative approach that we advocate for male infants, we offered the same approach to the parents, and to our surprise, the fistulas closed spontaneously after a few months of observation.

We now believe that both types (congenital and acquired) may occur in females babies. This condition is particularly common in Asiatic countries; therefore, our experience is a modest one [37].

Some of the cases described in the literature are obviously congenital. The reason why we believe that is because the patients have associated malformations, frequently seen in ARM. In addition, some of these patients have anal stenosis, presacral mass, or anterior mislocation of the anus. The congenital fistula has a wide tract with no inflammatory changes, and the histologic study of the inside lying shows bowel mucosa. The acquired type is more narrow, like the ones seen in males.

In summary, our current therapeutic approach consists in selecting the patients. A conservative approach (observation) is offered to infants (younger than 1 year), with a fistula behaving in the way described in males, without any of the malformations frequently associated to other ARM.

We try to simply observe the patient until the age of 18 months; if the fistula remains open, we repair it surgically.

On the other hand we will offer a surgical repair to a case that is older than 1 year, has a large fistula, has an evidence of being present since birth, has a strictured or mislocated anus, and has an abnormal sacrum or urogenital malformations frequently associated with ARM.

27.2.1 Surgical Treatment

Most patients come to us with a colostomy done at another institution. If the patient does not have a colostomy, we repair the defect without

it, but with a strict bowel preparation and fasting for a period of 7–10 days, receiving parenteral nutrition.

The patient is placed in prone position. A lacrimal probe is passed through the fistula (Fig. 27.3a – a, b). The perineal body is divided between the vestibular opening of the fistula and the opening in the anal canal (Fig. 27.3b). The mucosa of the fistula is resected, and multiple fine silk stitches are placed taking the anterior rectal wall in order to apply uniform traction (Fig. 27.3c). The anterior rectal wall is dissected away from the vaginal wall (Fig. 27.3d). The rectal wall is mobilized enough to reach the perineum comfortably (Fig. 27.3e). The perineal body is reconstructed (Fig. 27.3f). The anterior rectal wall is sutured to the perineal skin (Fig. 27.3g). Figure 27.3h shows the aspect of the operated area.

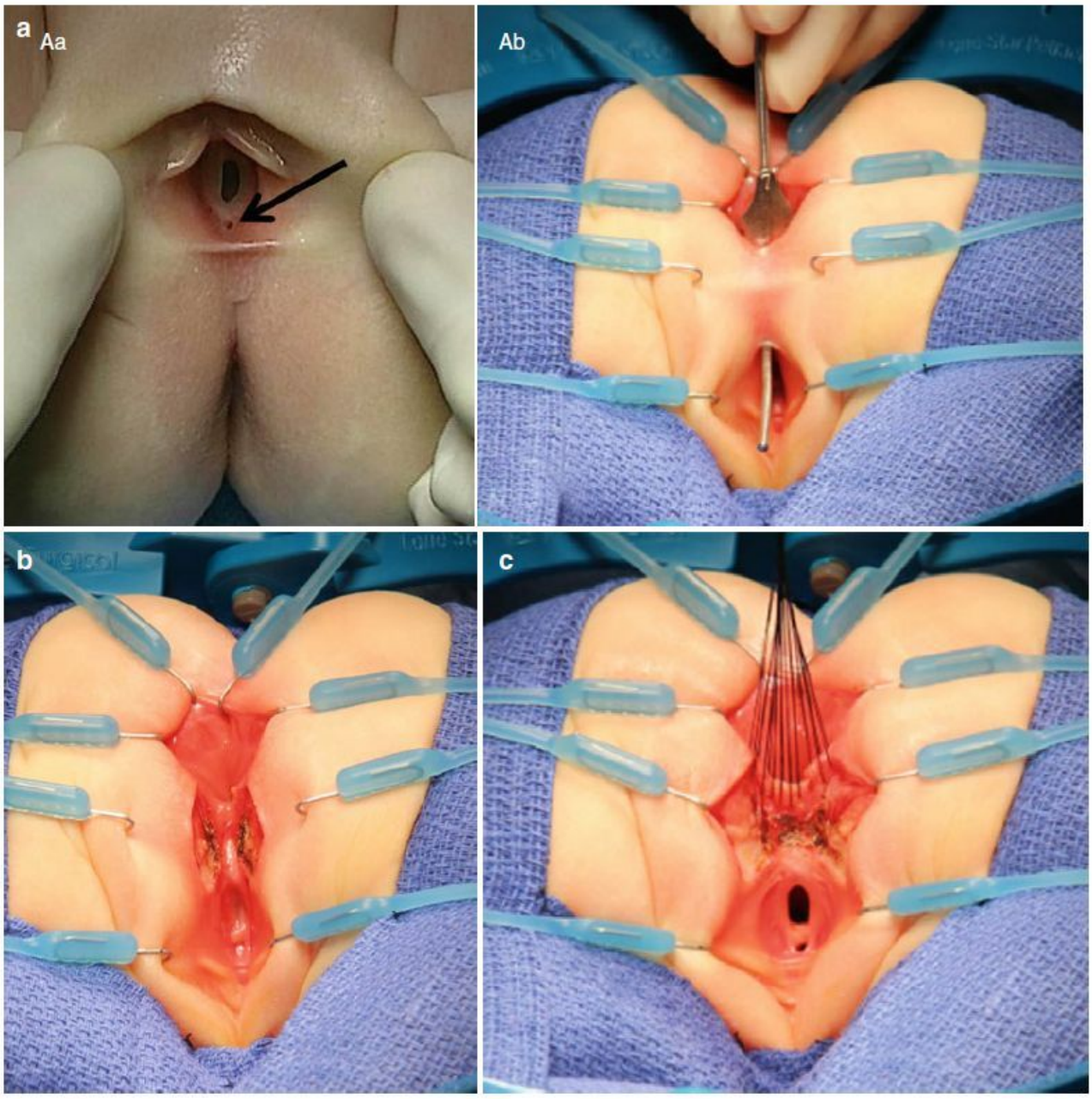

Fig. 27.3 Surgical repair of an H type of fistula in a female patient. (**a**) Fistula located in the vestibule. (*a*) Preoperative. *Arrow* showing the fistula. (*b*) Intraoperative, with lacrimal probe coming out through the rectum. Lacrimal probe passing through the fistula. (**b**) Divide all tissue of the perineal body. Fistula tract exposed. (**c**) Resected fistula tract. Multiple stitches placed on the anterior rectal wall to apply uniform traction. (**d**) Anterior rectal wall is mobilized dissected away from the vaginal wall. (**e**) Anterior rectal wall fully mobilized. (**f**) The perineal body is reconstructed. (**g**) The anterior rectal wall is sutured to the perianal skin. (**h**) Finished procedure

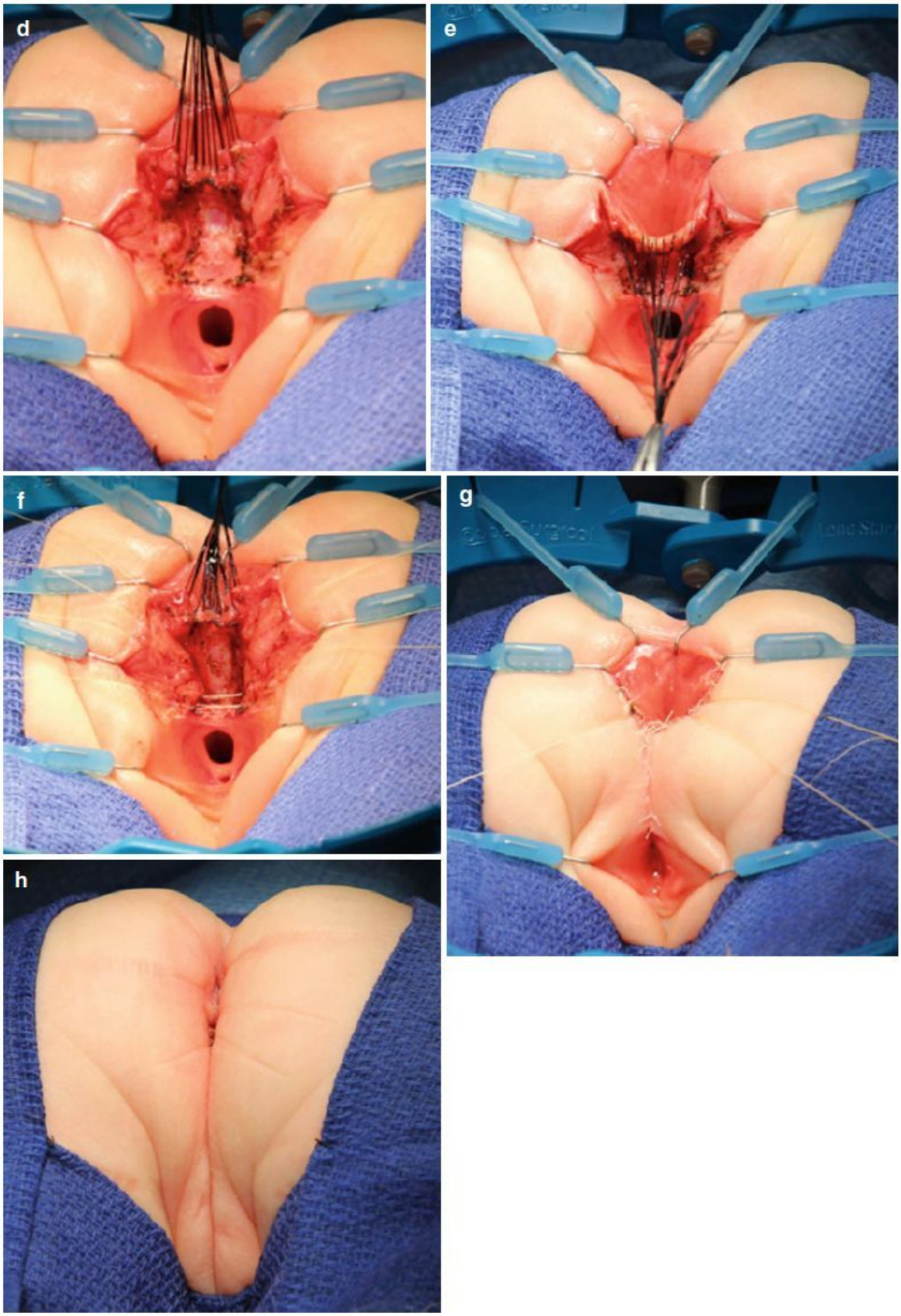

Fig. 27.3 (continued)